MEDICAL RECORD

Pain Screening & Initial Assessment

DATE: _____

PAIN SCREENING QUESTIONS: (if yes to either question, proceed to INITIAL PAIN ASSESSMENT)

1. Are you experiencing pain now? ☐ YES ☐ NO
2. Are you currently being treated for pain? ☐ YES ☐ NO

INITIAL PAIN ASSESSMENT

(complete diagram at right if patient affirms they have pain or are being treated for pain) ➔

PAIN INTENSITY (identify pain intensity instrument used)

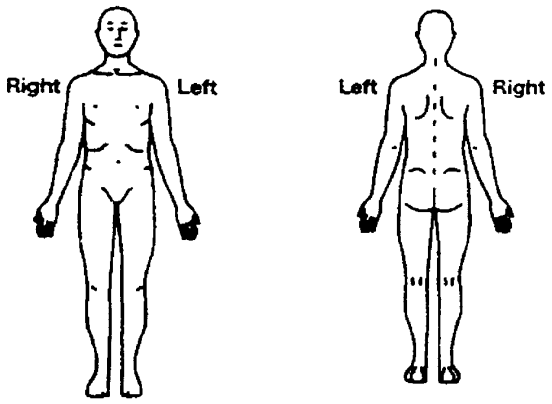
☐ Numeric Rating Scale
☐ Wong-Baker Faces
☐ FLACC Scale
☐ Oucher Scale
☐ Checklist of Non-Verbal Indicators
☐ COMFORT Scale
☐ CRIES Scale

Pain Level at Present: _____ Pain Level at Best: _____

Pain Level at Worst: _____ Acceptable Level of Pain: _____

INITIAL PAIN ASSESSMENT

Location (Mark or describe the location of pain):



IDENTIFY CURRENT AND PAST PAIN INTERVENTIONS (indicate interventions that have been ineffective)

PAIN INTERVENTIONS	CURRENT INTERVENTIONS (Check all that apply)	INEFFECTIVE (check only if ineffective)	PAST INTERVENTIONS (Check all that apply)	INEFFECTIVE (check only if ineffective)
Medications	☐	☐	☐	☐
Herbals	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Acupressure	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Cold or Heat	☐	☐	☐	☐
Distraction or Play	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Food	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐
Imagery	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Pet Therapy	☐	☐	☐	☐
Recreation Therapy	☐	☐	☐	☐
Positioning	☐	☐	☐	☐
Psychotherapy	☐	☐	☐	☐
Relaxation	☐	☐	☐	☐
TENS Unit	☐	☐	☐	☐
Other (specify):				

AGGRAVATING FACTORS:

- ☐ None
- ☐ Disease Process
- ☐ Treatment Side Effects
- ☐ Medication Side Effects
- ☐ Emotional Issues
- ☐ Physical Issues
- ☐ Spiritual Issues
- ☐ Other

QUALITY OF PAIN:

☐ Aching	☐ Dull	☐ Pinching	☐ Pressure	☐ Tender
☐ Burning	☐ Electric shock	☐ Pounding	☐ Sharp	☐ Throbbing
☐ Cramping	☐ Gnawing	☐ Pressing	☐ Shooting	☐ Tight
☐ Crushing	☐ Knot-like	☐ Prickling	☐ Stabbing	☐ Tingling
☐ Deep	☐ Pins & needles	☐ Pulsing	☐ Stretching	☐ Other _____

DESCRIBE PATTERN OF PAIN (onset, frequency, duration):

EFFECTS OF PAIN ON QUALITY OF LIFE:

☐ Activities of Daily Living	☐ Emotions or mood	☐ Mobility	☐ Work/School
☐ Appetite	☐ Enjoyment	☐ Relationship with others	☐ Other: _____
☐ Concentration	☐ Intimacy/Sexual Relations	☐ Sleep	
☐ Bowel or Bladder	☐ Memory	☐ Spirituality	

PATIENT'S PAIN GOAL (in their own words):

INTERVENTION(S) PROVIDED TODAY:

EVALUATION AND FOLLOW-UP:

_____ _____ _____

Signature | Print Name | Date